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ABSTRACT

This paper describes a systematic, coordinated approach to the delivery of health and social services to the rural elderly of Maine provided by the Kennebec Valley Regional Health Agency. Four points of the model are described which distinguish it from other models of coordination: (1) a strong medical orientation in the assessment process; (2) involvement of rural, primary health care centers as part of a service team; (3) location of rural coordinators in medically underserved areas; and (4) the provision of client, consumer and provider education. These four points illustrate how the provision of services to the rural elderly can be enhanced through primary care centers. The implementation of the model is also described, and the role of the agency in preventing or delaying unnecessary institutionalization is discussed both as a measure of cost effectiveness and as improving the quality of life and emotional well being of the rural elderly. (JAC)

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ENHANCING SERVICES TO THE RURAL ELDERLY

THROUGH PRIMARY CARE CENTERS

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at

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ENHANCING SERVICES TO THE RURAL ELDERLY

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In 1980, Primary Care Research and Demonstration Funds were provided to Kennebec Valley Regional Health Agency by a grant from Health and Human Services. These funds were to be used to develop and study a systematic, coordinated approach to the delivery of health and social services to the rural elderly.

Because of our status as a health agency and our long involvement in the health provision network, we were in a position to try an approach to service coordination different from the more common social service model. The model developed by Kennebec Valley Regional Health Agency has four points that we feel distinguishes it from other models of coordination.

1. A strong medical orientation in the assessment process.
2. Involvement of rural primary health care centers as a part of a service team.
3. Location of rurally based coordinators in medically underserved areas.
4. The provision of client, consumer, and provider education.

I will expand on each of the four points.

<u>First: a strong medical orientation in the assessment process.</u>

The Bureau of Maine's Elderly developed an assessment tool

to be used by the case managers of the Area Agencies on Aging that was primarily social service oriented. It consisted of the normal range of questions such as social supports, service needs, and so on. To this, we added as section specifically on health, addressing such questions as the client's current physical and mental health status; problem areas in need of attention; chronic illnesses; number of days of acute illness in the past six months; barriers to their use of medical care; and sources of care, i.e., primary, specialist, hospital, thus assuring that the medical needs, as well as the social needs, of the clients would be assessed. To further this emphasis, all of our service coordinators' backgrounds were medically oriented, either being Registered Nurses or medical social workers.

Second; involvement of rural primary care centers as part of service team.

The focus of our model was placed on coordinating and integrating existing health and social service networks at the primary care level. In most cases, there had been no previous communication between the Health Center--the major source of primary care in a given area--and the Area Agency on Aging whose main concern is the well-being of the elderly.

In keeping with the idea of using existing services and closer integration of health and social service networks, we contracted with the Area Agencies on Aging for the service coordinators. These coordinators were then housed in seven rural primary care centers to become an integral part of the Primary Health Care team. Thus they

have a foot in both the social service and health care camps and form a bridge between the two service areas. They are involved in staff meetings, case conferences, and assist in the development and follow-up of the client care plan developed by this team. They often make home visits to assess if their care plan is realistic in view of the home environment. They frequently act as a liaison person for the family, client, and the primary care porvider in bridging the often envitable communication gap. They are seen by the primary provider as a flexible resource person that can act now and do paperwork later! It's also important to emphasize here the dual nature of this placement; not only do health care providers become part of the total assessment and service provision process but also the primary care centers themselves acquire a social service component. The coordinators are influenced and guided by the orientation of that Agency because they are under the supervision of and directly responsible to an Area Agency on Aging. The coordinator herself represents the blending of the two orientations--medical and social service, and is able to integrate them through her participation in both spheres. She brings to the Center a closer tie between the discharge planning process of the acute facility and the primary care provider, often preventing the client from being lost in the transition. At the very least, she is able to maintain continuity in the continium of care process. The direct liaison with the coordinators to the Area Agencies on Aging has been most beneficial to the primary care providers in educating them about the State and local services available for the elderly in each of their respective

areas. Many times medical providers are not aware of the social services available. These are just a couple of the examples that help make it clear as to how this placement does provide a dual effect ~~in~~ broadening the scope and understanding of both service components.

Third: location of rurally based coordinators in medically underserved areas.

Each of the primary care centers which house our coordinators is located in a medical underserved area and serves a population with a higher than average proportion of elderly. Maine as a whole has an elderly population 12.5% compared to a nation-wide percent of 11.4%. One % may not be territly significant, however within the areas served by our coordinators, the percent may rise to as much as 25% of the total population.

Of the clients receiving service coordination through our model, only 1% had no impairment of functional abilities. This illustrates the already well-documented need of the elderly for social and medical service supports. In Maine and other rural areas, it is often the case that a formal service network just does not exist or exists in limited form. It was interesting to note the different between service availability as shown on paper and actual service restrictions brough about by either remoteness or lack of necessary funds. However, there is almost always an informal support system in place in rural areas. Friends, relatives, local government--a social network created over a lifetime of residency can be utilized to bridge gaps in and complement the more formalized networks.

People familiar with both the formal and informal services were hired as coordinators. They were most valuable in reaching out into the community to tie servies in with the primary care center and vis-versa. Coordinating the local high school Adult Education Program with speakers from the Center on health topics, relocating the local B/P clinic into the primary care center--small things maybe, but most effective for good public relations, visability and appropriate use of the Centers.

Fourth: the provision of client, consumer and provider education.

We conducted a knowledge and attitude survey addressing problems of the elderly; the results of this survey made it very clear education was needed to dispel some long standing misconceptions about aging and negative attitudes toward the elderly in general. The survey showed no correlation between job position, which implied level of education; and attitudes toward the elderly or, indeed, levels of knowledge about the elderly's special needs. A need for additional training in geriatrics and gerontology was certainly indicated for the staff of the primary care centers.

Given the staffing patterns of the rural primary care centers, i.e., usually a physician and/or physician assistant, and R.N. and office support staff, one or two-day programs away from the Center would virtually mean closing for that period and were, therefore, unrealistic. Programs had to be provided on site. For example, experts in a given field such as podiatry have spent a full day at each

site providing hands on care and demonstration. Other programs have been presented at one or two hour staff meetings with a variety of topics being addressed.

Consumer/client education programs are being provided at local meal sites, senior centers, health centers, church or grange basements wherever the elderly congregate. A variety of topics are available for example one, entitled Getting the Most Our of the Visit to Your Doctor has proven to be very popular. It is presented in a skit format which walks the client through the typical visit, then reflects on how the next visit can be more informative and meaningful. These presentations have also proven to be a benefit to the physicians, because they have enhanced the patient's ability to express concerns and needs during their office visits. Through these efforts we have reached, todate approximately 475 elderly citizens.

A series of health information brochures named MAINE-LY AGING are being developed to augment these programs as well as be available for the primary care centers to distribute to patients that demonstrate a need for a specific topic.

These four points--a medical orientation in the assessment, involvement of rural primary care centers, rurally based coordinators, and client, consumer and provider education--illustrate how the provision of services to the rural elderly can be enhanced through primary care centers.

Now let me tell you a little about our implementation and study of the model and the ever present issue of cost.

The first priority of the staff was to develop a list of all existing community services and resources for the elderly and establish cooperative working relationship with the service providers and members of the "informal network" (churches, community organizations, volunteers, local government government, etc.).

As previously stated, we soon realized the important of the informal network of services in rural areas. They were not only a valuable resource for services but also a referral mechanism when it came time to identify the at-risk population. From our study group, for instance, approximately 85% of referrals came from noninstitutional sources.

Next was the development of an assessment tool which I have already explained. The main point here to remember is that it is a comprehensive assessment addressing both medical and social service needs.

With these two pieces in place, then came the task of identifying the "at risk" population in need of service coordination. Our model made this phase of the project easy. We hired local people, physically located them in the primary health care centers of the rural areas served, developed a cooperative relationship with the other service providers and established contact with the informal network. We were now ready to start service delivery through this model.

During the first year of service, we identified a total of 623 clients. Of this number 413 (68%) needed only referral and

followup and 210 (32%) needed intensive service coordination. Of the 210, 21% previously had no source of primary care and 60% were at risk of institutionalization. With one of the goals of this project to reach persons in need of service before they have become institutionalized, we were gratified to find 85% were referred prior to reaching that point. The other 15% were referred to us from an institution (hospital, nursing home).

Another major goal of the project is to prevent or delay unnecessary institutionalization. Too many individuals are placed in nursing homes without truly belonging there because of a lack of necessary services to deal with their needs in their own homes. Money is the key factor in the equation. In today's reality, funding levels dictate the availability of services. Unfortunately for our cause of prevention of institutionalization, although society has in fact been willing to literally pay a high price for taking care of our elderly, the flow of money has gone in the wrong direction. In Maine, where the total Gross State Product is only $10 billion, the cost of hospital care is about $180 million. Only $8 million is spent on all home care. In Maine, again the elderly represent only 18% of all Medicaid recipients, yet they use 47% of all Medicaid payments, and 83% of that is for nursing home care. However, some steps to change this flow of money to nursing homes has taken place.

In 1980, Maine declared a moratorium on the approval of new nursing home beds and introduced legislation to expand home-based services for the elderly. The 110th Legislature enacted L.D. 1620 "An

Act to Require the Department of Human Services to Provide Home Based Care as an Alternative to Nursing Home Care." This has proven to be a very popular piece of legislation and has been refunded for the next biennium at a substantial increase. The Act is being watched closely by State governments and advocates for the elderly throughout New England.

The decision to bring home based services back into the mainstream of nursing care for the elderly may be the turning point in keeping older people in the mainstream of society--out of institutions. It is a goal of Maine's aging network to reduce nursing home residency from its current 7.7% of the over 65 population to no more than 5.6%. As you may know the national average is 5%. This figure is based on the Vermont Health System Agency's estimate than 10% of nursing home patients can be cared for in non-institutional settings--an estimate that Maine feels applies to its nursing home population as well.

The Kennebec Valley Regional Health Agency's model of service coordination and the research project designed to study the efficiency and effectiveness of the model, hopes to prove that the integration of the medical and social services networks in rural areas is another step in the right direction to help eliminate unnecessary institutionalization.

With cost containment leading all discussions of health care, we are painfully aware of the need to examine our program in terms of its potential cost savings.

The Bureau of Maine's Elderly has recently done a time

study that puts the average cost of service coordination at $20 per hour. During the coming year, we will be examining the cost of providing the various services that prevent or delay institutionalization.

While we feel that our model of service coordination designed to Enhance Services to the Rural Elderly through the Primary Care Centers is a more cost effective means of caring for our elderly, we must document that this is the case, for we are convinced that keeping people at home and independent is preferable to institutionalization in terms of their quality of life and their emotional well being.